Date: ________________ Case #: _____________

Welcome to Allentown Chiropractic Center, P.C.

CASE HISTORY

PERSONAL

Name: ____________________________ Date of Birth: __________ Age: ___
Address: __________________________ Phone #: ____________________
City ________________ST ___ ZIP_______ Cell #: ____________________
SS #: ______________________________ Work #: ____________________
Occupation: ________________________ Gender: (circle one) M or F
Employer: _________________________ Marital Status: ______________
Preferred Language Spoken: ___________ Number of Children: __________
E-mail address: ___________________________@ _______________________

By providing your email address, we may add you to our email list – only for occasional announcements or communication

Preferred method of communication: (circle one) Home phone # Cell # Work # Other: _________
Race: (circle one) African American American Indian Asian Native Hawaiian White Mix (2 races) No answer
Ethnicity: (circle one) Hispanic/Latino Non-Hispanic/Non-Latino No answer

* *How did you find out about us? :* ____________________________________ *

SPOUSE INFORMATION

Name: __________________________ Date of Birth: ___________________
SS #: ____________________________ Employer: _____________________

PAYMENT TYPE - PLEASE CIRCLE: SELF-PAY/CASH PERSONAL INSURANCE AUTO INS WORKERS COMP INS

INSURANCE

Insurance Carrier: __________________ Policyholder: ______________________
Policy/ID #: _________________________ Group #: _________________________
Relation to policyholder – you are: (circle one) Self Spouse Child
Policyholder Date of Birth: _________________________
Additional/Secondary coverage: ____
Policy/ID#: ____________________________ Group #: ______________________

PLEASE PROVIDE YOUR INSURANCE CARD(S) & DRIVERS LICENSE/PHOTO ID FOR COPYING

EMERGENCY CONTACT INFORMATION

Name: ________________________ Relation: ______________________________
Home #: ________________ Cell #: ________________ Work #: __________________

HEALTH HISTORY

Present health and any complaints or problems, including **why you are here**: _____________
____

Duration of this condition/how long you have had symptoms? _________________________

Is your problem due to: __Accident __Injury __Other: ________- Reported to: ___________

Diagnosis (by MD or others and approx. dates): ____________________________________

Patient Name: ______________________ #: __________ Date: ___________________

Have you been under previous Chiropractic Care? NO YES If yes, by whom, dates, and treatment areas: ____

Have you had any x-rays or MRIs? NO YES If yes, what facility, what area of the body, and approximate dates:____

What is the name of your primary care physician? __________________________________
Phone # and/or location: ____

Any other regular specialists or doctors? NO YES If Yes, list: _______________________
____

List any other health information, including any medications: __________________________
____

Do you have any allergies? NO YES If yes , list allergies: _________________________
____

Social habits: Smoking history? NO YES If yes , PAST / CURRENT, type & frequency: ______________
Drink alcohol? NO YES frequency: ______ SOCIAL / LIGHT / MODERATE / ALCOHOLIC / RECOVERING
Caffeine usage? NO YES Frequency: _________ # Cups per day: ___________
Recreational drug use, past or current? NO YES - Explain: type & frequency : ____________________
Eating/Diet: CONTROLLED / TOO LITTLE / TOO MUCH / SPECIAL DIET: ______________ / # MEALS/DAY: ________
Exercise: NO YES type: ______________________________frequency: ___________________

	TYPE OF SITUATION	*DOCTOR/HOSPITAL*	*DATES*
ILLNESSES:			
OPERATIONS:			
ACCIDENTS: (INCL. CAR OR FALLS)			
FRACTURES:			
PHYSICAL IMPAIRMENTS:			

If applicable, circle one: Do you wear glasses or contacts or none ?

FAMILY HISTORY

Please check if any of the following apply to any **family members** – parents, grandparents, children, siblings:

□ Cancer □ High Blood Pressure □ Diabetes □ Heart Problems/Stroke
□ Rheumatoid Arthritis □ Liver Disease □ High Cholesterol □ Alcohol/Drug Abuse
□ Genetic (inherited) disorder □ Depression/Psychiatric Illness □ Other: ___________